DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		495174	B. WING				C / <b>15/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2020
DULLES H	IEALTH & REHAB CENT	ER					
				н	ERNDON, VA 20171		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00			
	11/14/23 through 11/ <sup>7</sup> required for complian Federal Long Term C complaints were inve (VA00059943-substa VA00057410-substan VA00058287-unsubst The census in this 16 156 at the time of the consisted of 4 resider	survey was conducted 5/23. Corrections are ce with 42 CFR Part 483 are requirements. Three stigated during the survey ntiated without deficiency; tiated with deficiency; tantiated). 6 certified bed facility was survey. The survey sample at reviews.					
F 583 SS=D	CFR(s): 483.10(h)(1) §483.10(h) Privacy ai	nd Confidentiality.	F 5	83			12/26/23
		ht to personal privacy and r her personal and medical					
	telephone communication and meetings of familiation	dical treatment, written and ations, personal care, visits, y and resident groups, but the facility to provide a					
	right to privacy in his written, and electronic the right to send and mail and other letters materials delivered to	sonal privacy, including the or her oral (that is, spoken), c communications, including promptly receive unopened , packages and other the facility for the resident, ared through a means other					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE
Electroni	cally Signed						12/11/2023

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/12/2023 // APPROVED ). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495174	B. WING	B. WING			C 15/2023	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		15/2025	
					78 CENTREVILLE ROAD			
DULLES HEALTH & REHAB CENTER					ERNDON, VA 20171			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 583	Continued From page 1		F	F 583				
	§483.10(h)(3) The rest and confidential perso (i) The resident has the of personal and medic provided at §483.70(i) federal or state laws. (ii) The facility must at Office of the State Loo to examine a resident administrative records law. This REQUIREMENT by: Based on observation review and facility doo facility staff failed to e privacy for 1 Residents sample of 4 Residents The findings included For Resident #3, the f Resident #4, who was and wandering behav Resident #3's room at On 11/14/23 at 1:00 F observed in the hall s down hall. She was of the doorway and look On 11/14/23 at 1:20 F conducted with CNA f assistant-B) who state Residents that wander rooms however it is n stated that Resident #	sident has a right to secure onal and medical records. he right to refuse the release cal records except as )(2) or other applicable llow representatives of the ng-Term Care Ombudsman i's medical, social, and is in accordance with State i is not met as evidenced in, interview, clinical record cumentation review, the nsure the Resident's right to t (Resident #3), in a survey s. : facility staff failed to ensure is a Resident with dementia iors, did not wander into t will. PM Resident #4 was elf-propelling wheelchair observed to stop and stay in in the rooms. PM an interview was B (certified nursing			<ul> <li>F583</li> <li>1. Resident #4 was assigned 1:1 supervision to prevent wandering into others □ rooms. A mesh stop sign was installed to Resident #3 □ s door frame.</li> <li>2. Any resident is at risk of having the privacy compromised if a resident wanders into their room without their permission.</li> <li>3. All staff educated on resident right privacy.</li> <li>4. Administrator or designee will audi residents who are at risk of wandering ensure they are not wandering into other seidents. Tooms, daily for 5 days, we for 4 weeks, and monthly times two months. Results will be reviewed with QAA committee and adjustments will be made based on the results.</li> <li>5. AOC: 12/26/2023</li> </ul>	eir to it to er ekly the		

Facility ID: VA0128

If continuation sheet Page 2 of 6

F DEFICIENCIES CORRECTION OVIDER OR SUPPLIER EALTH & REHAB CENTI SUMMARY STA (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	, í	CROSS-REFERENCED TO THE APPROPR	(X3) DATE COMP ( 11/	0. 0938-0391 SURVEY LETED C 15/2023
OVIDER OR SUPPLIER EALTH & REHAB CENTI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page CNA B stated that Res	495174 ER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	( 11/ 3E	C 15/2023
EALTH & REHAB CENTI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page CNA B stated that Res	ER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	2978 CENTREVILLE ROAD HERNDON, VA 20171 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	3E	
EALTH & REHAB CENTI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page CNA B stated that Res	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	2978 CENTREVILLE ROAD HERNDON, VA 20171 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		(¥5)
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page CNA B stated that Res	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	HERNDON, VA 20171 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		(¥5)
(EACH DEFICIENCY REGULATORY OR L Continued From page CNA B stated that Res	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		(¥5)
CNA B stated that Re	2	1	DEFICIENCY)	COMPLETION DATE	
was asked about issu Resident #3 stated "T room from next door. doesn't knock it make urinal or if I'm washing door closed all the tim On 11/15/23 a review revealed that Residen keep his door closed t entering his room. On 11/15/23 at approx interview was conduct who stated she was a wander guard as a res August. When asked that the information or placement of a wande she stated that it was asked if she expected	ximately 10:30 AM an ted with Resident #3 who es with other Residents. that a lady wanders in his She comes in, but she s me mad if I'm using my g up. That's why I keep my he." of the clinical record at #3 has care planned to to deter Resident #4 from ximately 11:00 AM an ted with the Administrator ware that Resident #4 had a sult of the assessment in if it was her expectation in wandering behaviors and er guard be in the care plan her expectation. When I there to be interventions to	F 58	33		
Administrator was ma and no further informa Care Plan Timing and CFR(s): 483.21(b)(2)( §483.21(b) Comprehe §483.21(b)(2) A comp	de aware of the concerns ation was provided.   Revision i)-(iii) ensive Care Plans	F 65	57		12/26/23
rcduud Oreke OinwwAthpisla:pist DAaCC §§	bom from next door. Desn't knock it make rinal or if I'm washing oor closed all the tim on 11/15/23 a review evealed that Resider eep his door closed intering his room. In 11/15/23 at approv- terview was conduc ho stated she was a rander guard as a re- ugust. When asked hat the information of lacement of a wander he stated that it was sked if she expected rotect the privacy of tated that it was. uring the end of day dministrator was maind no further informa- are Plan Timing and FR(s): 483.21(b) Comprehe-	In 11/15/23 at approximately 11:00 AM an interview was conducted with the Administrator the stated she was aware that Resident #4 had a rander guard as a result of the assessment in ugust. When asked if it was her expectation that the information on wandering behaviors and lacement of a wander guard be in the care plan the stated that it was her expectation. When sked if she expected there to be interventions to rotect the privacy of other Residents and she tated that it was. uring the end of day meeting on 11/15/23, the dministrator was made aware of the concerns and no further information was provided. are Plan Timing and Revision FR(s): 483.21(b)(2)(i)-(iii) 483.21(b) Comprehensive Care Plans 483.21(b)(2) A comprehensive care plan must	boom from next door. She comes in, but she boesn't knock it makes me mad if I'm using my rinal or if I'm washing up. That's why I keep my boor closed all the time." In 11/15/23 a review of the clinical record evealed that Resident #3 has care planned to eep his door closed to deter Resident #4 from intering his room. In 11/15/23 at approximately 11:00 AM an iterview was conducted with the Administrator iho stated she was aware that Resident #4 had a rander guard as a result of the assessment in ugust. When asked if it was her expectation hat the information on wandering behaviors and lacement of a wander guard be in the care plan he stated that it was her expectation. When sked if she expected there to be interventions to rotect the privacy of other Residents and she tated that it was. uring the end of day meeting on 11/15/23, the dministrator was made aware of the concerns ind no further information was provided. are Plan Timing and Revision FR(s): 483.21(b)(2)(i)-(iii) 483.21(b) Comprehensive Care Plans 483.21(b)(2) A comprehensive care plan must	<ul> <li>bom from next door. She comes in, but she oesn't knock it makes me mad if I'm using my rinal or if I'm washing up. That's why I keep my oor closed all the time."</li> <li>in 11/15/23 a review of the clinical record evealed that Resident #3 has care planned to eep his door closed to deter Resident #4 from ntering his room.</li> <li>in 11/15/23 at approximately 11:00 AM an terview was conducted with the Administrator ho stated she was aware that Resident #4 had a ander guard as a result of the assessment in ugust. When asked if it was her expectation hat the information on wandering behaviors and lacement of a wander guard be in the care plan he stated that it was her expectation. When sked if here to be interventions to rotect the privacy of other Residents and she lated that it was.</li> <li>uring the end of day meeting on 11/15/23, the dministrator was made aware of the concerns and no further information was provided. are Plan Timing and Revision FR(s): 483.21(b)(2)(i)-(iii)</li> <li>483.21(b) Comprehensive Care Plans 483.21(b)(2) A comprehensive care plan must</li> </ul>	box from next door. She comes in, but she cosmit knock it makes me mad if I'm using my trinal or if I'm washing up. That's why I keep my coor closed all the time."       Image: constant of the clinical record evealed that Resident #3 has care planned to eape his door closed to deter Resident #4 from netering his room.         In 11/15/23 at approximately 11:00 AM an terview was conducted with the Administrator ho stated she was aware that Resident #4 had a ander guard as a result of the assessment in ugust. When asked if it was her expectation at the information on wandering behaviors and lacement of a wander guard be in the care plan he stated that it was her expectation. When sked if she expected there to be interventions to rotect the privacy of other Residents and she tated that it was.       F 657         uring the end of day meeting on 11/15/23, the dministrator was made aware of the concerns nd no further information was provided.       F 657         are Plan Timing and Revision       F 657         FR(s): 483.21(b)(2)(i)-(iii)       F 657

Facility ID: VA0128

If continuation sheet Page 3 of 6

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				RM APPROVE NO. 0938-039		
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF A. BUILDING	(X3) DA	(X3) DATE SURVEY COMPLETED			
		495174	B. WING		1	C 1/15/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
DULLES H	IEALTH & REHAB CENT	ER		2978 CENTREVILLE ROAD				
				HERNDON, VA 20171				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 657	Continued From page	e 3	F 65	57				
		7 days after completion of	1.00					
	the comprehensive a							
	(ii) Prepared by an interdisciplinary team, that							
	includes but is not limited to							
	<ul><li>(A) The attending physician.</li><li>(B) A registered nurse with responsibility for the resident.</li></ul>							
	resident.							
	(C) A nurse aide with resident.	responsibility for the						
		d and nutrition services staff.						
		cticable, the participation of						
		resident's representative(s).						
		be included in a resident's						
	medical record if the	participation of the resident						
	and their resident rep	presentative is determined						
	not practicable for the	e development of the						
	resident's care plan.							
		staff or professionals in						
		ined by the resident's needs						
	or as requested by th							
		ised by the interdisciplinary ssment, including both the						
	comprehensive and c							
	assessments.							
		「 is not met as evidenced						
	by:							
		on, interview, clinical record		F657				
	review and facility do	cumentation review, the		1. Facility reviewed and upda	ated care			
		ensure care plans were		plan for Resident #4 to include	-			
	reviewed and revised	-		care plan with wandering devic	e on			
		Resident (Resident #4) in a		12/7/2023.	. <b>f</b>			
	survey sample of 4 R	cesiaents.		2. Residents identified at risk				
	The findings included	i:		wandering were reviewed to er plans reflect their wandering, o wander-guard. Corrections we	r use of a			
	For Resident #4 the f	facility staff failed to add the		necessary.				
		sment results, the addition		3. The Interdisciplinary Team	will be			
	of the wander guard,	and interventions for		educated on timely review and				
	wandering to the com	nprehensive care plan.		the care plan.				

Event ID: 1ZGR11

Facility ID: VA0128

	-	ID HUMAN SERVICES				FORM	M APPROVED	
STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	BUILDING			PLETED	
		495174	B. WING				C 15/2023	
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE				
DULLES HEALTH & REHAB CENTER				2978 CENTREVILLE ROAD				
				H	IERNDON, VA 20171 PROVIDER'S PLAN OF CORRECTION		0(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page 4 On 11/14/23 at 1:00 PM Resident #4 was observed self-propelling the wheelchair down the hallway. She was observed to stop and stay in the doorway and look in the rooms. On 11/14/23 at 1:20 PM an interview was conducted with CNA B (certified nursing assistant-B) who stated they try to keep Residents that wander, out of other Residents rooms however it is not always possible. CNA B stated that Resident #4 has had to be redirected "on many occasions" out of Resident #3's room. CNA B stated that Resident #4 is easily		F	657	<ul> <li>4. Administrator or designee will aud new admissions for wandering risk we for four weeks and monthly times two months. Care plans will be updated ba on risk. Results will be reviewed with QAA committee and adjustments will b made based on results.</li> <li>5. AOC: 12/26/2023</li> </ul>			
	redirected. On 11/15/23 at appro- interview was conduct stated he has no issu asked about issues w stated "That lady wan She comes in, but she mad if I'm using my u Resident #3's room w #4, and Resident #4 h with wandering behave On 11/15/23 a review revealed that Resider keep his door closed entering his room. A review of the clinica "wandering risk asses 8/14/23. Resident #4 wandering and had a at that time. A review	ximately 10:30 AM an ted with Resident #3 who es with the facility. When with other Residents he uders in here from next door. The doesn't knock it makes me rinal or if I'm washing up." was next door to Resident has a dementia diagnosis viors. The clinical record the clinical record the table of the clinical record the table of						

Facility ID: VA0128

If continuation sheet Page 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SUR COMPLETE C         MAME OF PROVIDER OR SUPPLIER       495174       B. WING       11/15/2         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       2978 CENTREVILLE ROAD HERNDON, VA 20171       2978 CENTREVILLE ROAD HERNDON, VA 20171		-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 12/12/2023 APPROVED ). 0938-0391
495174     B. WING     11/15/2       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     2978 CENTREVILLE ROAD       DULLES HEALTH & REHAB CENTER     ID     PROVIDER'S PLAN OF CORRECTION     HERNDON, VA 20171       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     OC       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     OC       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE     OC       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE     OC	STATEMENT OF D	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         DULLES HEALTH & REHAB CENTER       2978 CENTREVILLE ROAD         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)	495174		B. WING			11/15/2023			
DULLES HEALTH & REHAB CENTER       HERNDON, VA 20171         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE       CC         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE       CC	NAME OF PROVIDER OR SUPPLIER				s	TREET ADDRESS, CITY, STATE, ZIP CO	ODE		
(X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE       CC         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE       CC	DULLES HEALTH & REHAB CENTER								
PREFIX TAG         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE         CC           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE         CC								(X5)	
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD B		COMPLETION DATE
F 657       Continued From page 5       F 657         address elopement risk or the wandering       assessment nor does it have any care planned       interventions for wandering.         On 11/15/23 at approximately 11:00 AM an       interview was conducted with the Administrator       who stated she was aware that Resident #4 had a         wander guard as a result of the assessment in       August. When asked if twice her expectation       that he information on wandering behaviors and         placement of a wander guard be in the care plan she stated that it was her expectation. When asked if she expected there to be interventions to protect the privacy of other Residents and she stated that it was.       During the end of day meeting the Administrator was made aware of the concerns and no further information as provided	ad as int Or int wh wa Au tha pla sh as pro sta Du wa	address elopement ri assessment nor does interventions for wand On 11/15/23 at appro- interview was conduct who stated she was a wander guard as a re August. When asked that the information o placement of a wand she stated that it was asked if she expected protect the privacy of stated that it was. During the end of day was made aware of the	sk or the wandering a it have any care planned dering. ximately 11:00 AM an cted with the Administrator aware that Resident #4 had a esult of the assessment in a fi it was her expectation in wandering behaviors and er guard be in the care plan is her expectation. When d there to be interventions to other Residents and she y meeting the Administrator he concerns and no further	F	657	DEFICIENC	Y)		

Facility ID: VA0128

If continuation sheet Page 6 of 6